

PATIENT'S BILL OF RIGHTS

The physicians and staff at The Institute of Facial and Cosmetic surgery are committed to provide quality health care and maintain the dignity and integrity of our patients. This Patient's Bill of Rights has been adopted to assure effective, quality care with satisfaction for the patients, the patient's family, and the physician.

It is your **RIGHT** as a patient:

1. To be fully informed prior to admission of the treatment to be received, complications, and outcome;
2. To refuse treatment and to be informed of the medical consequences of such refusal;
3. To be informed, prior to or at the time of admission and during stay, of services available in the facility and of any expected charges for which you may be liable;
4. To be afforded the opportunity to participate in decisions involving your health care, except when contraindicated;
5. To refuse to participate in experimental research;
6. To be assured confidential treatment of personal and medical records and to approve or refuse release to any individual outside the facility except in the case of transfer to another facility, or as required by law or third party payment contract;
7. To be treated with consideration, respect and full recognition of personal dignity and individuality, including privacy in treatment and in care for personal needs.

It is your **RESPONSIBILITY and DUTY** as a patient or guardian:

1. To cooperate with all persons providing potential your care and treatment.
2. To be respectful of the property, comfort, environment and privacy of other patients, not to be disruptive
3. To endeavor to understand and follow instructions concerning your treatment - to ask questions if you do not understand or need explanation
4. To provide accurate and complete information regarding your health problems and medical history, and to answer all questions as truthfully and completely as you can.
5. To be responsible in your payment for treatment and to be cooperative and timely in providing insurance information.
6. To request records in accordance with hospital and medical staff procedures and Virginia Law.

Patient Financing Agreement For _____

I hereby agree to the following regarding any and all services performed by

Suketu I. Patel, M.D., D.M.D David K. Moose, M.D. Dr. _____
in his/her capacity as Surgeon and the Institute of Facial and Cosmetic Surgery.
Physician Surgical Fee \$ _____ (estimate) to be paid ___ week(s) prior to surgery.
OR charges and Anesthesia \$ _____ (estimate) billed separately included

Please note, the fees listed are only estimated. The actual charges may vary. There is a
 \$500.00 \$200.00 or 10% charge of the total estimate (whichever is greater) if you
cancel your surgery less than 7 days prior to scheduled date. This fee may be applied
towards surgery rescheduled within one month of cancellation.

A charge of 1-1/2% PER MONTH (ANNUAL PERCENTAGE RATE 18%) will be
assessed on any balance outstanding beyond 30 days. Accounts unpaid after 45 days
shall be deemed delinquent.

I agree to pay any and all cost of collection including additional reasonable secretarial
and bookkeeping expenses, as well as reasonable attorney's fees.

My signature, or that of my legal guardian (in the case of dependent minors) to this
document will serve to acknowledge that I have read, understand and do agree with the
Rights/Responsibilities and Financial Arrangement listed on this document, and have
received a copy for my records.

Signed _____ date _____ witness _____